U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 18Apr2001

Case No: 2000-BLA-0642

In the Matter of

REAFORD SMITH
Claimant

v.

EASTERN COAL CORPORATION
Employer

THE PITTSTON COMPANY
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

APPEARANCES:

William Lawrence Roberts, Esq.
For the claimant

Lois A. Kitts, Esq.
For the employer

BEFORE: JOSEPH E. KANE
Administrative Law Judge

DECISION AND ORDER - DENYING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, 30 U.S.C. § 901 *et seq.* (the Act). Benefits are awarded to coal miners who are totally disabled due to pneumoconiosis. Surviv-ing dependents of coal miners whose deaths were caused by pneumoconiosis may also recover benefits. Pneumoconiosis, commonly known as black

lung, is a chronic dust disease of the lungs arising from coal mine employment. 20 C.F.R. § 718.201 (1996).

On April 14, 2000, this case was referred to the Office of Administrative Law Judges for a formal hearing. Following proper notice to all parties, a hearing was held on November 15, 2000 in Pikeville, Kentucky. The Director's exhibits were admitted into evidence pursuant to 20 C.F.R. § 725.456, and the parties had full opportunity to submit additional evidence and to present closing arguments or post-hearing briefs. Exhibits EX 7-9 were admitted post-hearing, in accordance with the ruling at the hearing.

The Findings of Fact and Conclusions of Law that follow are based upon my analysis of the entire record, arguments of the parties, and the applicable regulations, statutes, and case law. They also are based upon my observation of the demeanor of the witness who testified at the hearing. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. While the contents of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformance with the quality standards of the regulations.

The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. References to DX, CX and EX refer to the exhibits of the Director, the claimant, and the employer, respectively. The transcript of the hearing is cited as "Tr." and by page number.

ISSUES

The following issues remain for resolution:

1. whether the claim was timely filed;

2. the length of the claimant's coal mine employment;

3. whether the claimant has pneumoconiosis as defined by the Act and regulations;

4. whether the claimant's pneumoconiosis, if any, arose out of coal mine employment;

5. whether the claimant is totally disabled;

6. whether the miner's disability, if any, is due to pneumoconiosis; and

7. whether the evidence establishes a change in conditions or a mistake in a determination of fact within the meaning of Section 725.310, including whether the previous decision was mistaken as to whether the evidence established a material change in conditions pursuant to § 725.309(d).

(Tr. 7-9; DX 93). Additional issues are preserved for appeal. (Id.).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and Procedural History

The claimant, Reaford Smith, was sixty-four years old at the time of the hearing and has a seventh grade education. He has one dependent, his wife, for purposes of augmentation of benefits. (Tr. 9, 15, 17; DX 1, 5, 29.15).

The claimant testified that all of his coal mine employment was underground and required bending, stooping, pushing, pulling, and lifting. He stated that he lifted items weighing over one hundred pounds every day. He last worked in June 1988. He last smoked in 1993 or 1994. (Tr. 10, 15).

The claimant filed his first claim for benefits under the Act on August 2, 1976. It was finally denied on June 12, 1980. (DX 29).

The claimant filed a second claim for benefits on October 15, 1993. (DX 1). Following a formal hearing on March 22, 1995, Administrative Law Judge Frederick D. Neusner awarded benefits on September 8, 1995. Judge Neusner found that the evidence established a material change in conditions pursuant to 20 C.F.R. § 725.309(d), pneumoconiosis under § 718.202(a)(4), causation pursuant to § 718.203(b), total disability under § 718.204(c)(4), and causation pursuant to §718.204(b). (DX 44, 49). The employer appealed. (DX 51, 54). The Benefits Review Board ("the Board") vacated the findings under 20 C.F.R. §§ 718.202(a)(4) and 718.204(c) and (b) on September 27, 1996. (DX 58). On remand, Judge Neusner found that the claimant
failed to establish the existence of pneumoconiosis pursuant to 20 C.F.R. § 718.202(a)(4) and total disability pursuant to

§ 718.204(c)(4).[1] Accordingly, benefits were denied on August 20, 1997. (DX 70). The claimant appealed that denial to the Board. (DX 72a, 74). On July 21, 1998, the Board affirmed the denial. (DX 79).

The claimant filed a request for modification of the previous denial on September 18, 1998. (DX 80). The employer was notified of the request, and subsequently controverted based on both its liability and the claimant's eligibility. (DX 88). Following denial of the claim by the District Director, Office of Workers' Compensation ("OWCP") (DX 85), a hearing was held on September 15, 1999 before Administrative Law Judge Thomas F. Phalen, Jr.. Afterwards, the employer filed a motion concerning the medical evidence. On October 1, 1999, Judge Phalen issued an Order remanding the claim for further development of the medical evidence. Following the development of such, the denied the request for modification on January 7, 2000. (DX 92). The claimant timely requested a formal hearing, and the claim was referred back to the Office of Administrative Law Judges ("OALJ") on April 14, 2000. (DX 92, 93).

Length of Coal Mine Employment

The employer conceded at least eleven years of coal mine employment. The claimant alleges nineteen years. (Tr. 8). The OWCP computed sixteen years. (DX 20).

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[1] In his August 20, 1997 Decision and Order on Remand - Denying Benefits, Judge Neusner footnoted that:

> [There is] a possible conflict regarding the nature of Claimant's last usual coal mine job. In testimony at the formal hearing, Claimant testified that his last job as a mine foreman required him to travel back and forth between two mine sections, which took about 45 minutes each way. Furthermore, he stated that the job required a lot of walking, bending, stooping, pushing, and pulling, and sometimes lifting objects which weighed as much as 100 or 150 pounds. TR 22-23. On the "Description of Coal Mine Work and Other Employment" form which Claimant signed under oath on October 15, 1993, however, the Claimant said his last coal mine job as a mine foreman entailed eight hours of sitting. DX 04. Consequently, I find that Claimant's last usual coal mine job entailed periodic, moderate exertion. Accordingly, it is questionable whether Dr. Baker's opinion if credited, would warrant a finding of total disability. DX 12. Even if Claimant's last coal mine job entailed sustained manual labor, I would find that the preponderance of the medical opinion evidence establishes that Claimant's mild impairment would not prevent him from performing such work.

The Act fails to provide specific guidelines for computing the length of a miner's coal mine work. However, the Benefits Review Board consistently has held that a reasonable method of computation, supported by substantial evidence, is sufficient to sustain a finding concerning the length of coal mine employment. *See Croucher v. Director, OWCP*, 20 BLR 1-67, 1-72 (1996) (en banc); *Dawson v. Old Ben Coal Co.*, 11 BLR 1-58, 1-60 (1988); *Niccoli v. Director, OWCP*, 6 BLR 1-910, 1-912 (1984). Thus, a finding concerning the length of coal mine employment may be based on many different factors, and one particular type of evidence need not be credited over another type of evidence. *Calfee v. Director, OWCP*, 8 BLR 1-7, 1-9 (1985).

The claimant's Social Security earnings record (DX 32, 29) shows the following coal mine employment:

> Canada Coal Company and Elkhorn Creek Coal Company, 3rd quarter 1971 thru 3rd qtr. 1976, with no earnings in the 4th qtrs. of 1972 and 1975 = 19 quarters.
>
> Eastern Coal Company, 2nd qtr. 1977 through 2nd qtr. 1988 (employment ended June 1988) = 44 quarters.

Accordingly, the claimant has shown a total of 63 quarters of coal mine employment, or 15 3/4 years, and I so find.

Modification

Section 725.310 provides that a claimant may file a petition for modification within one year of the last denial of benefits. Modification petitions may be based upon a change in condition or a mistake in a determination of fact. 20 C.F.R. § 725.310(a).

In deciding whether the claimant has established a change in conditions, I must "perform an independent assessment of the newly submitted evidence, in conjunction with evidence previously submitted, to determine if the weight of the new evidence is sufficient to establish the element or elements which defeated entitlement . . .." Napier v. Director, OWCP, 17 BLR 1-111, 1-113 (1993). *See also* Nataloni v. Director, OWCP, 17 BLR 1-82, 1-84 (1993).

In deciding whether the prior decision contains a mistake in a determination of fact, I must review all the evidence of record, including evidence submitted since the most recent denial. New evidence, however, is not a prerequisite to modification based upon a

mistake of fact. Nataloni, 17 BLR at 1-84; Kovac v. BCNR Mining Corp., 14 BLR 1-156, 1-158 (1990), *aff'd on recon.* 16 BLR 1-71, 1-73 (1992). *See also* O'Keefe v. Aerojet-General Shipyards, 404 U.S. 254, 257 (1971). Rather, the factfinder is vested "with broad discretion to correct mistakes of
fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." O'Keefe, 404 U.S. at 257.

The following is a summary of the medical evidence submitted with the instant request for modification. The previously submitted medical evidence is summarized in Judge Neusner's September 8, 1995 and August 20, 1997 decisions. (DX 49, 70). No medical evidence was entered in the 1976 claim. (DX 29).

Medical Evidence

A. Chest X-rays

Ex.No.	Date of X-ray	Film Qual.	Physician/ Qualifications[2]	Interpretation
DX 92	6/22/92	2	Wiot/BCR, B	Completely negative.
DX 92	6/22/92	2	Broudy/B	0/0. Scattered calcifications.
DX 92	1/18/93	1	Broudy/B	Chronic changes with some peribronchial fibrosis and scattered calcifications. 0/0.
DX 92	5/26/93	1	Broudy/B	Chronic changes with some peribronchial fibrosis in

[2] The symbol "BCR" denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc. or the American Osteopathic Association. 20 C.F.R. § 727.206(b)(2).

The symbol "B" denotes a physician who was an approved "B-reader" at the time of the x-ray reading. A B-reader is a physician who has demonstrated expertise in assessing and classifying x-ray evidence of pneumoconiosis. These physicians have been approved as proficient readers by the National Institute of Occupational Safety & Health, U.S. Public Health Service pursuant to 42 C.F.R. § 37.51 (1982).

				mid and lower zones, and scattered calcifications. 0/0.
EX 4	5/26/93	1	Fino/B	Completely negative.

Ex.No.	Date of X-ray	Film Qual.	Physician/ Qualifications	Interpretation
DX 92	8/11/94	1	Spitz/BCR, B	0/0. Tortuous aorta. Decreased vascularity in upper lobes may represent emphysema. Fr (old healed fracture).
DX 92	8/11/94	2	Wiot/BCR, B	0/0. Co (atherosclerotic aorta). Fr.
DX 59	7/11/95	-	Amin (Hospital)	(Portable chest). No acute cardiopulmonary disease.
DX 59	10/2/95	-	Amin (Hospital)	No acute cardiopulmonary disease. Mild flattening of hemidiaphragm.
DX 59	12/14/95	-	Amin (Hospital)	Chronic obstructive lung disease. Mild flattening of hemidiaphragm.
DX 59	1/25/96	-	Amin (Hospital)	Mild chronic obstructive lung disease with no acute cardiopulmonary disease.
DX 59	1/31/96	-	Amin (Hospital)	Mild chronic obstructive lung disease with no acute cardiopulmonary disease.
DX 59	4/27/96	-	Amin (Hospital)	Mild chronic obstructive lung disease.

DX 59	9/27/96	-	Amin (Hospital)	Mild chronic obstructive lung disease with no acute cardiopulmonary disease. Diffuse interstitial fibrosis bilaterally.

Ex.No.	Date of X-ray	Film Qual.	Physician/ Qualifications	Interpretation
DX 71	5/6/97	-	Amin (Hospital)	Chronic obstructive lung disease. Prominent pulmonary arteries. Mild flattening of hemidiaphragm. Fr.
DX 92	5/6/97	3	Broudy/B	0/0. Peribronchial fibrosis and scattered calcifications.
DX 92	4/17/98	3	Wiot/BCR, B	0/0. Atherosclerotic aorta.
DX 92	4/17/98	-	Fino/B	Completely negative.
DX 92	4/17/98	2	Spitz/BCR, B	Completely negative.
DX 92	5/17/98	2	Broudy/B	0/0. Scattered fibrotic changes and multiple scattered calcifications.
DX 92	7/8/98	3	Wiot/BCR, B	0/0. Atherosclerotic aorta.
DX 92	7/8/98	2	Spitz/BCR, B	Completely negative.
DX 92	7/8/98	-	Fino/B	Completely negative.
DX 92	7/8/98	2	Broudy/B	0/0. Scattered fibrotic changes and multiple scattered calcifications.

DX 92	6/25/99	-	Abbott	Stable appearance of the chest without evidence of active disease as compared to 8-11-94. No silicosis. Some calcified granulomata. Tortuous aorta. Fr.

Ex.No.	Date of X-ray	Film Qual.	Physician/ Qualifications	Interpretation
DX 92	6/25/99	1	Spitz/BCR, B	0/0. Tortuous aorta. Decreased vascularity in upper lobes may represent emphysema. Fr. Linear strands in LLL.
DX 92	6/25/99	2	Wiot/BCR, B	0/0. Co. Fr.
DX 92	6/25/99	1	Broudy/B	Some post-inflammatory scarring in the left mid zone and a few scattered calcifications in either lung.
DX 92	8/19/99	-	Amin	Chronic obstructive lung disease, mild flattening of hemidiaphragm bilaterally. Fr.
DX 92	8/19/99	1	Spitz/BCR, B	0/0. Linear strands. Fr.
DX 92	8/19/99	3	Wiot/BCR, B	0/0. Co. Fr.
EX 4	8/19/99	1	Fino/B	Completely negative.
DX 92	8/23/99	-	Amin (Hospital)	Chronic obstructive lung disease, flattening of

				hemidiaphragm bilaterally. Fr.
DX 92	8/23/99	2	Spitz/BCR, B	0/0. Linear strands. Fr.
DX 92	8/23/99	U/R	Wiot/BCR, B	Unreadable.
EX 4	8/23/99	U/R	Fino/B	Unreadable.
DX 92	9/15/99	U/R	Spitz/BCR, B	Unreadable.
DX 92	9/15/99	U/R	Wiot/BCR, B	Unreadable.
DX 92	9/17/99	2	Spitz/BCR, B	0/0. Fr.
DX 92	9/17/99	3	Wiot/BCR, B	0/0. Co. Fr.
DX 92	9/21/99	2	Spitz/BCR, B	0/0. Linear strands. Fr.
DX 92	9/21/99	3	Wiot/BCR, B	0/0. Co. Fr. Ef (pleural effusion).
DX 92	10/9/99	1	Dahhan/B	Completely negative.
DX 92	10/9/99	2	Broudy/B	0/0. Scattered fibrotic changes and multiple scattered calcifications.
CX 2	8/10/00	-	Blake (Hospital)	COPD with question of pulmonary artery hypertension.
EX 4	8/10/00	1	Fino/B	0/0. Cardiomegaly and congestive heart failure.

Ex.No.	Date of X-ray	Film Qual.	Physician/ Qualifications	Interpretation

B. Pulmonary Function Studies

Date	Ex. No.	Age/Hgt.	FEV1	FVC	FEV1/ FVC	MVV	Coop/ Comp.

5/6/97	DX 71, 80	60/69"	2.97	4.68	63.4%	- -	- -
6/25/99	DX 92	62/69"	2.85	4.44	64%	102	Good
			* 3.02	4.36	69%	113	
8/25/99	DX 92	63/69.0"	0.33	0.50	56.9%	22	Poor effort

Dr. N.K. Burki opined that the above study was invalid due to less than optimal effort, cooperation and comprehension: "Observer comments and curve shapes indicate poor effort." (DX 92).

Date	Ex. No.	Age/Hgt.	FEV1	FVC	FEV1/ FVC	MVV	Coop/ Comp.
10/9/99	DX 92	63/67.5"	2.19	3.53	62%	64.5	Good/
			* 2.02	3.00	67%	75.0	Good

Dr. Dahhan opined that the pre-bronchodilator MVV and all of the post-bronchodilator values were invalid due to inadequate effort. (DX 92).

* Results obtained post-bronchodilator.

C. Arterial Blood Gas Tests

Date	Physician	pCO2	pO2	Ex. No.
9/27/96	Hussain (Hospital)	39.8	68.0	DX 59
9/30/96	Hussain (Hospital)	36.2	70.0	DX 59
5/6/97	Hussain	38.1	75.0	DX 71
6/25/99	Broudy	38.8	75.5	DX 92
8/19/99	Hussain	40.1	70.0	DX 92

8/23/99	Hussain (Hospital)	47.5	48.0	DX 92
	Dr. Burki opined that the above study was valid. (DX 92).			
10/9/99	Dahhan	31.9 ** 28.3	71.7 91.9	DX 92
8/10/00	Hussain (Hospital)	37.5	65.0	CX 2

** Results obtained with exercise.

D. Medical Opinions

The claimant was hospitalized from July 11 to 13, 1995 due to recurrent pain in the jaw and neck, diaphoressis, severe weakness, and passing out spells since morning. The attending physician was Dr. Imtiaz Hussain. The discharge diagnoses were angina, atherosclerotic heart disease, status post myocardial infarction, status post coronary angioplasty, hypertension, and osteoarthritis. (DX 59).

The claimant was rehospitalized on January 31, 1996 due to worsening breathlessness, cough with mucopurulent expectoration, wheezing, chest congestion, headache, nasal discharge and congestion, and fever with chills for the past seven days. The attending physician was again Dr. Hussain. Black lung and COPD were noted by history. Examination revealed vesicular breathing with prolonged expiration, bilateral scattered rhonchi, and basilar crackles. An x-ray revealed evidence of black lung with chronic obstructive pulmonary disease. The final diagnoses on February 6, 1996 were acute exacerbation of chronic obstructive pulmonary disease, black lung, atherosclerotic heart disease, hypertension, old myocardial infarction, and status post angioplasty. (DX 59).

On September 27, 1996, the claimant was admitted again to the hospital. The attending physician was Dr. Hussain. An x-ray was noted to be positive for black lung. The final diagnoses on October 1, 1996 were acute exacerbation of COPD, black lung, hypertension, and atherosclerotic heart disease. (DX 59).

The claimant was next hospitalized from July 8 to 11, 1998 due to worsening breathlessness, cough with mucoprulent expectoration,

recurrent chest pains, smothering, and swelling of the feet for the past eight days. The attending physician was Dr. Hussain. Examination revealed vesicular breathing with prolonged expiration, bilateral scattered rhonchi, and occasional basilar crackles in the left base. An x-ray was positive for COPD. An EKG revealed nonspecific anterior T wave changes suggestive of old ischemia, old anterior infarct. The final diagnoses were acute exacerbation of chronic obstructive pulmonary disease, chest pain, atherosclerotic heart disease, gastroesophageal reflux disease, and hypertension. (DX 80).

Dr. Hussain, who specializes in pulmonary and critical care medicine, issued a report on August 28, 1998. He stated that he has been the claimant's physician for the past three years, and that the claimant has "a history of Chronic Obstructive Pulmonary Disease, Coal Workers' Pneumoconiosis, HTN, Coronary Artery Disease, Status Post Coronary Angioplasty and Gastroesophageal Reflux Disease." The smoking history was one pack of cigarettes per day from 1969 to present. A pulmonary function test showed

a low FEV1/FEV ratio at 63.4%, which Dr. Hussain found to be suggestive of black lung. The pO2 on the arterial blood gas test was also low, suggestive of COPD secondary to black lung. Dr. Hussain noted that "[c]hest x-rays obtained over the years reveal evidence of Coal Workers' Pneumoconiosis and COPD." In a later report, August 6, 1999, Dr. Hussain noted that the January 25, 1996, May 6, 1997, and April 17, 1998 x-rays were positive for COPD. Dr. Hussain reasoned that:

> Mr. Smith was awarded his Black Lung Disability in 1988, but the decision was recently reversed due to lack of supportive medical findings. It is my professional medical opinion as a Pulmonologist that in view of the aforementioned findings, you must concur that Mr. Smith does indeed suffer from Black Lung due to his long term exposure to coal, coal dust and rock dust.
>
> Mr. Smith is limited in his physical capabilities and is unable to perform even routine daily activities such and (sic) mowing the law, climbing a flight of stairs, shopping or gardening because of episodes of severe shortness of breath, wheezing and cough. His quality of life is diminished and his lifestyle altered due to his failing physical condition.

> It is therefore my opinion that Mr. Smith is no longer able to be gainfully employed and is permanently and totally disabled. Due to constant exposure to coal, coal dust, and rock dust in the mines for nearly 20 years, Mr. Smith should therefore be entitled to and receive all the benefits due to him regarding his condition under the Black Lung Law.

(DX 80, 92; see also DX 59, 67 and 69, handwritten office notes and laboratory test results).

Dr. Bruce C. Broudy examined the claimant on June 25, 1999 on behalf of the employer. He had previously examined the claimant on August 11, 1994. Examination of the chest was normal. A pulmonary function study revealed a very mild obstruction with no significant improvement after bronchodilation. An arterial blood gas test showed mild resting arterial hypoxemia with elevation of the carboxyhemoglobin level indicating continued exposure to smoke. An x-ray was positive for some post-inflammatory scarring in the left mid zone and a few scattered calcifications in either lung, but negative for pneumoconiosis. Dr. Broudy diagnosed

chronic bronchitis with very mild chronic airways obstruction related to smoking, obesity, coronary artery disease, and hypertension. He found "no objective evidence of any significant deterioration in his pulmonary status since his last visit here in 1994," and opined that the claimant has the respiratory capacity to resume his former coal mine employment. (DX 92).

In his August 6, 1999 report, based on his July 20, 1999 examination, Dr. Hussain referred to the x-ray and study results noted in his earlier report. He stated that the claimant was "unable to be gainfully employed due to severe breathlessness, wheezing and cough with mucoprulent expectoration" and that the claimant "should avoid dust and fumes at all times due to severity of his lung disease." He also noted that the claimant has angina with tightness and pain in his chest upon exertion. (DX 92).

Dr. Broudy was deposed on August 18, 1999. He testified as to his examination findings. (DX 92).

Dr. Gregory J. Fino reviewed medical records on behalf of the employer and issued a report on August 17, 1999. Dr. Fino previously reviewed records on November 1, 1994. He concluded that coal workers' pneumoconiosis was absent, and that even if it were present,

the claimant does not have a pulmonary impairment. (DX 92). Dr. Fino is board-certified in internal and pulmonary medicine. (EX 4).

The claimant was hospitalized at South Williamson Appalachian Regional Hospital from August 23 to 27, 1999. The attending physician was Dr. Imtiaz Hussain. X-rays revealed evidence of COPD. A pulmonary function study, with poor effort, showed severe airway obstruction. The final diagnoses were acute exacerbation of chronic obstructive pulmonary disease, hypertension, and diabetes mellitus. (DX 92).

Dr. Jerome F. Wiot was deposed on September 8, 1999. He testified that:

> [C]oal workers' pneumoconiosis is manifested radiographically by the presence of small, rounded and sometimes irregular opacities, which tend to begin in the upper lung fields. The more often, interestingly enough, they early occur in the right upper lung field rather than the left. These rounded or irregular opacities are more often what we call a q size, which is a part of the classification system, but ... you can have p's and r's, but more often q size opacities of coal workers' pneumoconiosis and sometimes t's.
>
> ... If the disease process becomes more severe, it will progress down the lung, so it goes down the chest rather than up.

As to the claimant, Dr. Wiot testified that the x-rays do not evidence coal workers' pneumoconiosis, and that there has not been any change in the x-rays since 1992. (DX 92).

Dr. Abdul K. Dahhan examined the claimant on behalf of the employer on October 9, 1999. He reviewed the claimant's histories, symptoms, and medications. Examination of the chest showed increased AP diameter with hyper resonancy to percussion. Auscultation revealed bilateral expiratory wheeze with no crepitation or pleural rubs. An electrocardiogram revealed extensive anterior wall myocardial infarction. An arterial blood gas test showed minimum hypoxia at rest; the values were normal with exercise. A pulmonary function study indicated a mild obstructive ventilatory defect, with reversibility undetermined due to the invalidity of the post-bronchodilator test. An x-ray was negative for pneumoconiosis. Dr. Broudy also reviewed other medical records. He concluded that the

claimant did not have coal workers' pneumoconiosis, but a non-disabling mild obstructive ventilatory defect due to smoking. He explained that:

> [The claimant] has not had any exposure to coal dust since 1988, a duration of absence sufficient to cause cessation of any industrial bronchitis that he may have had. Also, he is being treated with various bronchodilators, which indicates that his treating physician believes that it is responsive to such therapy, a finding that is inconsistent with the permanent adverse affects of coal dust on the respiratory system.

Dr. Dahhan is board-certified in internal and pulmonary medicine. (DX 92).

Dr. Broudy reviewed additional medical evidence on behalf of the employer and issued a report on October 26, 1999. His opinions remained the same. (DX 92).

Dr. Hussain issued another examination report on June 2, 2000. He again reviewed the claimant's histories and symptoms. Dr. Hussain noted that the claimant had underwent a cardiac catherization and balloon angioplasty in 1995, and a repeat angioplasty one year later. The claimant was on eleven medications

for his various medical conditions. He still smoked. Examination revealed bilateral rhonchi. X-rays from 1998 - 2000 showed prominent pulmonary arteries and chronic obstructive pulmonary disease. Arterial blood gas tests from 1998 - 2000 showed a low pO2 suggestive of COPD secondary to black lung. Pulmonary function studies from 1998 - 2000 showed a low FEV1/FVC ratio suggestive of black lung. Dr. Hussain diagnosed ASHD, COPD, and hypertension. He related the diagnoses to "exposure to coal, coal dust and rock dust for 20+ years on a continual daily basis. Also working around diesel equipment for 13 years. Smoking is secondary cause." As to the severity of an impairment and the cause(s), Dr. Hussain wrote that:

> Pt. experiences shortness of breath, wheezing and cough, with chest pain and weakness. Pt. has greenish/grayish sputum on occasion. Accentuated bronchovascular markings in lung bases (9/99), pulmonary arteries prominent, mild flattening of hemidiaphragm, fibrotic strand in left base.

> ASHD - is major contributing factor causing chest pain.
>
> COPD - is major contributing factor causing shortness of breath, wheeze, cough and weakness.

On a separate form, he checked off that the claimant is totally disabled related primarily to pneumoconiosis. He stated that the claimant is "no longer able to be gainfully employed due to severity of his disease and due to numerous recent hospitalizations." (CX 1).

Dr. Broudy was deposed on June 21, 2000 after reviewing Dr. Hussain's latest report. Dr. Broudy commented that:

> [T]his most recent report ... suggest that there were abnormal results of the lung function, but he doesn't actually have the report of the spirometric results. He says that the pO2 was low, but doesn't give an actual result. He also mentions the chest x-ray as showing chronic obstructive pulmonary disease, but doesn't mention any reading suggesting coal workers' pneumoconiosis. This report does not alter in any way the previous conclusions that I reached after reviewing the previous medical evidence.

(EX 1).

The claimant was hospitalized again from August 10 to 16, 2000. (CX 2). The records do not reveal much information other than the x-ray and study results listed above.

At the employer's request, on September 4, 2000, Dr. Robert A. Wise performed a review of medical records from May 1993 to October 1999. He concluded that "Mr. Smith does not have coal workers' pneumoconiosis. He has no more than a slight respiratory impairment which is not the result of inhalation of coal dust. As of October, 1999, he retained the respiratory functional capacity for heavy work activity such as that required of a coal miner." (EX 2). Dr. Wise did not provide any reasoning.

Dr. David M. Rosenberg performed a medical record review on behalf of the employer on September 6, 2000. He concluded that:

> [I]t can be appreciated that the overwhelming majority of Mr. Smith's B reading interpretations have been totally negative for the presence of a pneumoconiosis. Serial evaluations of films by multiple B readers have revealed there clearly is no evidence of parenchymal interstitial involvement. His pulmonary function test (sic), at worst, have demonstrated a mild degree of airflow obstruction, which undoubtedly relates to his long and probably continued smoking history (based on his elevated carboxyhemoglobin levels). While arterial blood gas studies have at times revealed mild decreases in PO2, he had a significant increase in his PO2 with exercise. The latter indicates that the alveolar capillary bed within his lungs is intact, and clearly he has no interstitial lung disease based on this measurement of PO2 with exercise. Also, Mr. Smith does not have persistent bibasilar end-inspiratory rales on auscultation of his chest. It should be noted that his chest X-rays have demonstrated evidence of chronic obstructive pulmonary disease. When all the above information is looked at in total, with a reasonable degree of medical certainty, Mr. Smith does not have coal workers' pneumoconiosis. Any pulmonary impairment present, which at worst is mild airflow obstruction, is related to his long history of cigarette smoking. He does not have any impairment consequent to his coal mine employment and any potential dust exposure which occurred.

Dr. Rosenberg is board-certified in internal, pulmonary, and occupational medicine. (EX 3).

Dr. Fino performed another record review on September 15, 2000. He concluded that:

> There is no valid, objective evidence of any respiratory impairment. Dr. Dahhan's evaluation of this man revealed normal blood gases at rest and with exercise in October of 1999.
>
> This man did have significant hypoxia and some hypercarbia during an exacerbation of his chronic obstructive lung disease in August of 1999. However, the blood gas abnormalities did return to normal two months later. Such improvement in a short period of time indicates a smoking related condition. Coal mine dust

> related conditions are permanent and would not be expected to improve over time.

(EX 4).

Dr. Fino issued a supplemental report on October 21, 2000. His opinions remained the same. (EX 6).

Dr. Wise issued a supplemental report on October 15, 2000 concerning his review of the August 2000 hospitalization. He stated that:

> The evidence submitted is incomplete and does not allow a determination of Mr. Smith's residual functional capacity at the time that the evidence was collected. It appears that he was hospitalized, but the nature of the reason for hospitalization cannot be determined with a reasonable degree of medical certainty. The treatment regimen would suggest that he was being treated for acute bronchitis or an exacerbation of COPD, but this would be speculative. The only evidence bearing on a diagnosis of coal workers' pneumoconiosis is the chest radiograph report which does not contain any evidence of this disorder. Thus, this additional limited evidence does not change my previous conclusions based on previous medical records.

Dr. Wise is board-certified in internal and pulmonary medicine. (EX 5).

Dr. Wise was deposed on November 6, 2000. He testified that he reviewed eleven x-rays from June 22, 1992 to October 9, 1999 and found no evidence of coal workers' pneumoconiosis. He further testified that "[c]oal workers pneumoconiosis is a fixed fibrotic or scarring disease which would not respond to broncho-dilators," and that simple pneumoconiosis generally does not progress absent further coal dust exposure. An improvement in oxygenation with exercise is not compatible with silicosis or coal workers' pneumoconiosis, but is compatible with chronic bronchitis. (EX 9).

Dr. Rosenberg was deposed on November 7, 2000. He also testified that simple coal workers' pneumoconiosis does not progress absent further exposure, and generally does not cause any impairment. (EX 7).

Dr. Fino was deposed on November 10, 2000. He testified that:

> The blood gas studies when this man in his chronic normal steady state, not acutely ill, were all within normal limits. There was no hypoxia. There was a blood gas from August of 1999 when he was admitted to the hospital with an acute infection in his lungs at that time his blood oxygen level was very abnormal. His pO2 was only 48 but he was treated for this infection. He improved and subsequent blood gas were now in the normal range. So this was an acute illness not representative of a chronic underlying pulmonary condition.

(EX 8).

DISCUSSION

Material Change in Conditions

No medical evidence was submitted with the 1976 claim and the OWCP made no specific findings in that claim. Therefore, there is nothing for the claimant to show a material change in conditions from and he bears no burden under § 725.309(d).

Applicable Law

Because the claimant filed his application for benefits after March 31, 1980, this claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. Under this part of the regulations, claimant must establish by a preponderance of the evidence that he has pneumoconiosis, that his pneumoconiosis arose

from coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis. Failure to establish any of these elements precludes entitlement to benefits. *See Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-112 (1989).

Pneumoconiosis and Causation

Under the Act, pneumoconiosis is defined as a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b). Section 718.202(a) provides four methods for determining the existence of pneumoconiosis: X-ray evidence, biopsy or autopsy evidence, application of a presumption, and medical opinion evidence. §§ 718.202(a)(1)-(4). As the record does not

contain any biopsy evidence and none of the referenced presumptions are applicable, pneumoconiosis cannot be established under either § 718.202(a)(2) or (3).

Under the provisions of § 718.202(a)(1), chest x-rays that have been taken and evaluated in accordance with the requirements of § 718.102 may form the basis for a finding of the existence of pneumoconiosis if classified in Category 1, 2, 3, A, B, or C under an internationally-adopted classification system. An x-ray classified as Category 0, including subcategories 0/-, 0/0 and 0/1, does not constitute evidence of pneumoconiosis. Under § 718.202(a)(1), when two or more x-ray reports are in conflict, consideration must be given to the radiological qualifications of the physicians interpreting the x-rays.

As none of the newly submitted x-ray readings were classified as positive for pneumoconiosis, I find no change in condition. Weighing all of the x-ray readings of record, I find no mistake of fact. While the record contains four positive readings, the preponderance of all the x-ray readings is negative for pneumoconiosis. Therefore, the evidence does not show pneumoconiosis under § 718.202(a)(1).

Under § 718.202(a)(4), a claimant may also establish the existence of pneumoconiosis, notwithstanding negative x-rays, by submitting reasoned medical opinions. However, this regulation further provides that any such finding by a physician must be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examinations, and medical and work histories.

While the opinion of a treating physician is entitled to additional weight, the opinion of Dr. Hussain is not accorded much weight in this case because it is not a properly documented nor well-reasoned opinion. Dr. Hussain refers to allegedly positive x-ray readings for pneumoconiosis, but the readings of Dr. Amin show only findings of chronic obstructive pulmonary disease in addition to one x-ray finding of "diffuse interstitial fibrosis bilaterally" (which was not specifically identified as any particular disease process). Although Dr. Hussain then related the COPD to coal dust, which makes for a finding of "pneumoconiosis" as defined under §718.201, Dr. Hussain nevertheless indicated that he was beginning with an x-ray positive for black lung in addition to COPD. As found earlier, none of the newly submitted x-rays were classified as positive for pneumo-

coniosis and Dr. Hussain did not refer to Dr. Amin's reading of interstitial fibrosis.

Dr. Hussain also based his finding of pneumoconiosis on the low FEV1/FVC ratio and the decrease in pO2 retention, as well as the claimant's symptoms. However, he did not review the increase in oxygenation with exercise nor the variability in the FEV1/FVC ratio.

Neither Dr. Hussain nor the previous physicians who diagnosed pneumoconiosis addressed the nature of the disease process as opposed to that from smoking. Therefore, their opinions provide no reasoning to weigh against the opinions of the employer's experts who attribute any and all pulmonary findings to cigarette smoking.

As such, I find that the preponderance of the medical opinion evidence is negative for both medical and statutory pneumoconiosis.

Based on the foregoing, I find that the claimant has not established a mistake of fact in the previous determination that he did not establish pneumoconiosis, nor a change in condition.

Total Disability and Causation

None of the valid pulmonary function studies of record produced qualifying values as determined by Appendix B to Part 718. Therefore, I find that the claimant has not shown total disability under § 718.204(c)(1).

None of the arterial blood gas tests of record produced qualifying values as determined by Appendix C to Part 718, except for the study of August 23, 1999 which was obtained during a hospitalization for an acute illness. Therefore, I find that the claimant has not shown total disability under § 718.204(c)(2).

The record does not contain any evidence of cor pulmonale with right-sided congestive heart failure. Therefore, total disability cannot be shown under § 718.204(c)(3).

Dr. Hussain opined that the claimant was totally disabled. While his opinion is unclear as to whether he found the claimant to be totally disabled from a pulmonary (not cardiac) standpoint alone, assuming arguendo that he did, his opinion is still unreasoned. He did not address the non-qualifying results of the pulmonary function studies and arterial blood gas tests. While he implied a connection,

Dr. Hussain did not explain any connection between the claimant's COPD and the acute exacerbations which apparently arise from infections. Dr. Hussain's qualifications in pulmonary medicine are also unknown.

Dr. Baker's opinion of total disability, which was rendered in 1993, was addressed by Judge Neusner. He found that the opinion was outweighed by the other numerous opinions that the claimant was not totally disabled. I concur with that finding, and also find that the most recent evidence is more probative on the issue of disability than an opinion rendered in 1993.

Considering this, the continuing non-qualifying results of the objective studies, and the newly submitted opinions of Drs. Broudy, Dahhan, Fino, Wise, and Rosenberg that the claimant is not totally disabled from a pulmonary or respiratory standpoint, I find no mistake in the previous determination and no change in condition.

Based on the foregoing findings under §§ 718.204(c)(1)-(4), I find that the claimant is not totally disabled from a pulmonary or respiratory standpoint.

Conclusion

The claimant has not established a mistake of fact in the previous determinations on pneumoconiosis and total disability, nor has he established a change in condition. Therefore, his request for modification must be denied.

In reaching the above conclusion, I have applied the various versions to the regulations recently promulgated by the Department of Labor. 65 Fed. Reg. 79920-80107 (Dec. 20, 2000). I note this decision was rendered only after giving due consideration to the arguments of the parties, existing case law, and both the new and old regulations, including the new regulations at issue in *National Mining Association v. Chao*, No.: 100CN0386(EGS) (D. D.C.)

ORDER

The claim of REAFORD SMITH for benefits under the Act is denied.

A
JOSEPH E. KANE
Administrative Law Judge

NOTICE OF APPEAL RIGHTS:
Pursuant to 20 CFR § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this Decision and Order by filing a Notice of Appeal with the Benefits Review Board at Post Office Box 37601, Washington, D.C. 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.